Connecticut Department of Social Services
Making a Difference

Testimony before the Joint Hearing of the Human Services and Appropriations Committees Regarding the Request for Approval of A New 1915(b) Managed Care Waiver For Medicaid Families and Children (HUSKY A)

Presented by
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Good afternoon, Senators Harp and Doyle, Representatives Geragosian and Walker, and distinguished members of the Appropriations and Human Services Committees. My name is Claudette Beaulieu, and I am Deputy Commissioner of the Department of Social Services. I am here on behalf of Commissioner Michael Starkowski, who is recovering from surgery. I am joined by David Parrella, Director of Medical Care Administration, and Kevin Lurito and Maria Dominiak, our Mercer actuaries, as well as other department staff.

I come before you today to request your approval for the State of Connecticut's application for a new 1915(b) Medicaid managed care waiver for the HUSKY A-covered population of children, parents, relative caregivers and pregnant women. The number of beneficiaries in the HUSKY A program now exceeds 331,000 -- 108,736 adults and 222,633 children.

Connecticut is one of over 40 states to operate a managed care program in public health coverage. Moreover, the private and public employment sectors (including Connecticut state employees) routinely are served by managed health care services.

The federal Centers for Medicaid and Medicare Services (CMS) is viewing this as a request for new waiver, rather than an extension of the waiver that we have been operating under Connecticut public policy since 1995. CMS has requested a new waiver because of the significant changes that Connecticut has incorporated into the program design during the past two years. These changes have largely focused on eight main areas.

- Greater accountability for provider rates and client access;
- clarification of the applicability of Freedom of Information to the MCOs;
- measures to address access to dental services as part of the settlement of the *Carr vs. Wilson-Coker* litigation;
- increases in provider reimbursement;
- state administration of the pharmacy benefit under a carveout from managed care;
- a procurement process linked to the start of the Charter Oak Health Plan for uninsured Connecticut adults;

- expansion of eligibility to cover more parents, relative caregivers and pregnant women;
- and the development of Primary Care Case Management as an additional option for the managed care population.

Basic role of managed care organizations

Besides provider recruitment and network development, utilization management, and claims-related activities, the managed care organizations provide HUSKY beneficiaries with ongoing services such as:

- professional customer service by phone;
- referral assistance;
- health education and outreach;
- provider location and appointment scheduling assistance;
- reminders to schedule well care exams; - access to out-of-network providers, as necessary;
- quality improvement initiatives;
- specialized programs for pregnant women;
- specialized programs for members with chronic conditions, such as asthma and diabetes;
- care coordination; and
- case management.

Before Connecticut implemented Medicaid managed care in 1995, families were "on their own" in an unmanaged environment under a fee-for-service model. Well-child visits, immunizations and other critical benchmarks were seldom achieved. The absence of managed care coordination also brought lack of care coordination and increased costs from so-called "doctor shopping," in which fee-for-service clients go from doctor to doctor with no medical rationale and no cost control for taxpayers.

Today, fourteen years later, immunization rates for HUSKY children are among the highest for any state Medicaid program in the nation. Our well child visit rate has doubled since the start of the program in 1995. While low

birthweight births are still higher than in the state population in general, we have made significant strides in the entry of women into prenatal care during the first trimester of pregnancy.

The managed care program has brought considerable value on the administrative side for the department, including the performance of activities like prior authorization, network administration, and timely reporting that have helped us to contain costs while we have increased eligibility for children, parents, and pregnant women.

We are today the primary payer for 40% of the births in our state. All uninsured children born in Connecticut are eligible to be covered for the first 4 months of life, so that we have no uninsured newborns in our state. HUSKY is now the primary payer for children and their low-income parents, many of whom might otherwise have been without coverage. These results are something to be proud of, and they would not have been achievable without a managed care approach, and the continuing support of our Legislature.

Despite the changes that the program has undergone during the past year and a half, these are positive signs that the commitment to the delivery of primary care to this population by our providers and the MCOs remains strong. The very fact that we report on these and other measures every month to our colleagues on the Medicaid Managed Care Council illustrates what the visibility and accountability that the delivery of primary care for low-income children and families has been able to achieve.

Network Accountability

The three MCOs continue to report newly signed provider contracts that increase member access and capacity. Through a combination of rate increases, relationship building with providers and provider representatives, and effective negotiating by the MCOs, the HUSKY networks for primary care providers continue to improve, as do the networks for specialists and other medical practice provider types. In addition to contracted providers, the MCOs have successfully negotiated out of network provider care to be accessed for clients who need such services. DSS is very active in our oversight of the provider network progress. We closely monitor and reports on all network contracting, out-of-network encounters, progress on negotiations and assessing roadblocks that prevent or stall provider participation in the program. All of these activities embrace the importance

of working with the provider community and the MCOs for the sake of being able to deliver all levels of services to our members.

Contractor Oversight

In addition to aggressive monitoring of provider networks by the department, the MCOs are required to regularly submit documentation, data and reporting on an array of functions ranging from operational activities, service utilization to financial expenditures. The MCO reporting includes utilization, grievance, provider network turnover, prior authorization, case management, financial data as well as documentation and performance measures of their quality and performance improvement initiatives and outcomes of consumer surveys. Additional monitoring includes review of encounter data by department staff as well as review of data related to member disenrollment, appeals, complaint and other information received directly by the department or our contractors, such as HUSKY InfoLine.

An independent review of the MCOs is conducted annually by the department's external quality review contractor. This review includes a review of MCO polices and procedures for compliance with contractual and federal requirements, validation of performance measures, calculation of performance measures, and a site visit to review MCO operations.

Freedom of Information and MCO Transparency

In November 2007, Governor Rell directed DSS to terminate the contractual managed care responsibilities of HUSKY managed care organizations because of the failure of the two largest contractors to meet the administration's disclosure standards under the Freedom of Information Act. The Governor's transparency policy also resulted in the department issuing a procurement announcement and, later, contracts that included full FOIA compliance as a baseline requirement.

These new transparency provisions ensure that the managed care contracts with providers and their rates are open to all, including clients, advocates, legislators and the public. Over the next year, Health Net, WellCare, and Anthem left the HUSKY program. The new procurement and the resulting contracts have established transparency as a non-negotiable condition of participation—all MCOs must comply with the Freedom of Information Act.

Through the procurement process, we now contract with one MCO that we contracted with previously, the Community Health Network of Connecticut, and two new MCOs: Aetna Better Health and AmeriChoice by United Healthcare.

Increases in Provider Reimbursement

Over the biennium, the Governor and the General Assembly provided for significant increases in provider rates to support the HUSKY and Medicaid fee-for-service programs. Following the 2007 session, the department moved to make significant investments in provider fees for a range of Medicaid providers, including physicians and hospitals. In an unprecedented move, the department directed the new MCOs that they cannot pay less for a Medicaid-covered service than the listed fee for the same service as promulgated by the department. This new, higher "Medicaid floor" became the minimum starting point for rate negotiations. The rates that were calculated for the at-risk MCOs from August 1, 2008, forward reflected this level of investment in provider reimbursement as a way to improve and maintain access to medically necessary services.

The Carveouts: Dental, Pharmacy, Behavioral Health

Medicaid managed care began as a full-risk (meaning the MCOs are "at risk" for medical costs in return for a per-member/per-month capitation rate), all-inclusive program in 1995, as approved by the General Assembly. Over the years, the marked progress in the expansion of access to primary care was not matched by a commensurate improvement in access to the two services that the MCOs, themselves, were most likely to sub-contract--namely, behavioral health and dental services.

The Dental Carveout

In 2008, dental services were carved out from the MCO contracts as part of the settlement of *Carr vs. Wilson-Coker* litigation. The settlement also resulted in significant investments in dental provider fees for children and the expansion of the provision of dental services through safety net providers. With these changes, we have seen dramatic improvements in both the number of participating providers (773 dental providers are now enrolled, compared to 367 in July of '08), and the number of Medicaid-eligible children who are receiving dental services has increased substantially.

The Behavioral Health Carveout

Behavioral health services were carved out of the HUSKY program on January 1, 2006. These services are now administered through a joint DSS and DCF contract with ValueOptions. This carve-out was necessary to provide both DSS and DCF with direct contractual control over the management of behavioral health services funded by the two departments. This arrangement recognized the fact that many of the HUSKY-covered children with greatest behavioral health needs are involved with DCF, and that DCF is the funder of a multitude of community-based behavioral health services that are necessary to keep children out of institutions.

The Pharmacy Carveout

Under federal law, states are able to obtain a rebate from pharmaceutical manufacturers equal to the difference between what the state pays and what the best price available is for the material cost of a given drug. However, states are only able to access these rebate benefits when they pay directly for the pharmaceutical products. Medicaid managed care organizations are not eligible to benefit from the federal pharmacy rebates and that advantage is lost to the state under a capitated system that includes pharmacy.

With the development of the preferred drug list and pharmacy prior authorization in our fee-for-service program, the cost advantages for maintaining pharmacy as part of the at-risk contracts began to disappear. Effective February 1, 2008, pharmacy services were carved out from the MCO contracts and are now managed directly for the HUSKY population by DSS pharmacy staff and our specialty contractors.

In conclusion, the dental, behavioral health and pharmacy costs make up a smaller percentage of the total HUSKY budget. As such, they lend themselves to administration through an integrated statewide carve-out. The medical program is substantially larger than the other three programs combined and it lends itself to traditional managed care approaches which balance quality and access objectives with cost-containment.

The Procurement Strategy

In the fall of 2007 Governor Rell directed the suspension of the at-risk MCO contracts because of the FOIA issue. As an interim measure, the department offered the MCOs a per member per month administrative fee to continue to serve the HUSKY population. By the end of calendar year 2008, the HUSKY population had moved to either fee-for-service or this non-risk arrangement with two of the former MCOs (Anthem and the Community Health Network of Connecticut).

In early 2008, the department released a request for proposals that would address concerns about network accountability, provider rates, and transparency, while also providing a vehicle to address the crisis of the uninsured. The procurement reinstituted MCO services under full-risk

capitation contracts and leveraged participation in the Charter Oak Health Plan for uninsured adults who are not eligible for HUSKY, fee-for-service Medicaid, State-Administered General Assistance or Medicare. The integrated procurement offered the opportunity to promote continuity of health care services across age and income groups as enrollees move from HUSKY to Charter Oak.

We have recently completed the transition of the HUSKY population to two new MCOs on February 1, 2009, Aetna Better Health and AmeriChoice by United Healthcare, and one participant from the previous at-risk era, Community Health Network of Connecticut (our longtime non-profit contractor). These same three health plans are currently providing insurance services to over 7,100 previously uninsured persons in the Charter Oak program (with an additional 3,600 individuals now eligible to enroll in our health plans).

Primary Care Case Management

Primary care case management (PCCM) is a care model where individual medical providers are paid a monthly fee to provide coordinated case management for their patients and offer non-traditional services, such as extended office hours.

In 2007, the General Assembly directed the department to establish a pilot program for the HUSKY population. Enrollment in the pilot began in February 2009 in the Waterbury and Willimantic areas. As of today, we have executed contracts with seven medical practices, including two federally qualified health centers (FQHCs), which together comprise 53 primary care providers. Reimbursement for services is on a fee-for-service basis. Providers are paid a monthly management fee of $7.50 per month per enrolled HUSKY member. PCCM providers agree to provide enhanced services, including additional office hours and a dedicated case management specialist. As of April 1, 200 clients are enrolled.

We are committed to increasing the enrollment in PCCM in the months ahead. On this point, to better reflect the state legislature's intent, and the department's ongoing commitment to a PCCM pilot, I have attached to our testimony our recommended revision to the initial waiver submission for your consideration today.

The pilot program seeks to test PCCM an alternative model of managed care in comparison to our traditional managed care model. It is worth noting that the pilot is not meant to suddenly supplant the current managed care service environment for hundreds of thousands of beneficiaries.

The department is working very closely with providers to implement the pilot. Our provider advisory group's three subcommittees on care coordination, disease management, and data management and program evaluation each meet several times monthly to build the program even as we serve clients enrolled in the program.

We chose to begin in the areas where there is a base of interested providers, seeing both children and adults. It is true that providers from other parts of the state are enthusiastic about participating in the pilot; however, only in Waterbury and Willimantic is there a broad representation from the adult care community and from the pediatric community.

The initiative holds promise and we are intent on testing the model objectively and planfully. We recognize that some states, such as North Carolina and Oklahoma, have experienced significant cost savings and improvements in clinical outcomes from their PCCM programs through building close collaborative relationships with the primary care communities. These states' successes were not experienced overnight. North Carolina's program required a six-year collaborative effort with providers for it to be successfully developed and spread. Unlike Oklahoma, which required over 70 additional staff members to implement their program, we are developing PCCM with existing staff and volunteer providers.

Future Plans and the FQHCs

Federally qualified health centers occupy a unique position in federal regulations in that the state must make a supplemental payment to bring the reimbursement received for an episode of care from an MCO up to the level of the prospective encounter rate established by the department.

Over the years this resulted in a cumbersome process where the department collected data to issue these "wraparound" payments. Payments to the

FQHCs were further compounded by issues with provider credentialing. In order to resolve these issues the department and the FQHCs entered into a unique agreement whereby the MCOs will now make all payments to the FQHCs at the DSS prospective rate. This eliminates the need for the "wraparound" process and expedites payments to the FQHCs.

In addition, the department and the MCOs have agreed to delegate the credentialing of individual medical providers to the FQHCs, themselves. Finally, starting in September, 2009 the department has agreed to assume responsibility for processing FQHC claims for services rendered to HUSKY beneficiaries. The FQHCs will continue to have a contractual relationship with the MCOs for the purposes of care coordination, quality assurance, performance improvement initiatives and the coordination of Early Periodic Screening, Diagnosis, and Treatment services. From that point forward all FQHC claims will be billed directly to the department's fiscal intermediary, Electronic Data Systems. The cost of these services will be offset by a commensurate reduction in the rates paid to the MCOs, which means that the MCOs will remain at risk for FQHC services.

Conclusions

I hope that I have been able to summarize the major changes in the program since the last time we brought the waiver before the committees in 2006. The new waiver period will be for two years (July 1, 2009, through June 30, 2011).

We believe that it is clear that the department has made extensive efforts to be creative and responsive in making program changes and enhancements. For the past 14 years, HUSKY has been the cost-effective vehicle that has allowed us to expand eligibility for and access to medical services to children, to parents and relative caregivers, and to pregnant women across the state.

We now cover children and parents in HUSKY A up to 185% of the federal poverty level and pregnant women up to 250% of the federal poverty level. HUSKY is the largest single payer for pediatric and obstetrical care in the State of Connecticut and serves as platform from which additional efforts at health care expansions like HUSKY B and Charter Oak have been launched. I would like to thank our partners on the Medicaid Managed Care Council,

including some of you who sit here today, for your support and constructive criticism in our common goal, and I urge you to approve this waiver application so that we can move it forward in a timely manner for final federal approval.

Approval of the State of Connecticut's waiver application will enable the continued operation of the HUSKY A/Medicaid managed care program for the next two years. It is worth noting that the Governor's budget recommendation provides for expected caseload growth in the HUSKY program, and those increased costs have been factored into the recommendation for the biennium.

This waiver must be approved to support the program that we have in place *today*. The waiver provides for the three managed care organizations that are currently serving our HUSKY members, with networks adequate to meet the needs of more than 330,000 covered lives. This waiver also establishes a platform for primary care case management.

Most important, as the state confronts an unprecedented multi billion dollar deficit, we need a program that will provide the most cost-effective solution for delivering more than $700 million in medical services. While there are other models that may have appeal and are worth examining in the future, there is no other model that we know definitively would provide better care at lower cost on July 1.

Thank you for your kind attention. With me to answer your questions are DSS staff experts David Parrella, Mark Schaefer, Rose Ciarcia, Robert Zavoski, and Lee Voghel, as well as Maria Dominiak and Kevin Lurito from Mercer.